APPLICATION FOR ADMISSION

Facility Choice: Holden_____ Oakdale_____ Wachusett Respiratory Unit_____

Applicant's Name:_____ Date of Birth:_____ Age:_____

Address: _____

Street City State Zip code

Telephone #:_____ U.S. Citizen: ☐ YES ☐NO Sex: M/F

Religion:_____ Social Security Number: _____

Were you in the armed forces?_____If so, Dates of service: _____

Marital Status: ☐Married ☐Divorced ☐Widowed ☐Separated ☐Never Married

Name of Spouse: _____ Primary Language:_____

Primary Care Physician:_____ Telephone: _____

Financial Manager

(Please provide the information below for the person(s) who handles financial matters for the applicant)

Name:_____ Relationship:_____

Address: _____

Street City State Zip code

Telephone:_____ Email:_____

Please check type of authority (if any) and provide a copy with this application:

☐Legal Guardian ☐Durable Power of Attorney ☐Conservator ☐Representative Payee

Health Care Proxy

Name:_____ Relationship:_____

Address: _____

Street City State Zip code

Telephone:_____ Email:_____

*Please include a copy of the health care proxy with this application

If no health care proxy please provide the name of an emergency contact:

Name:_____ Telephone:_____

Current Living Situation

Applicant is currently living at:_____

Does applicant live alone? ☐ Yes ☐ No with whom?_____

Address:_____

Street City State Zip code

Contact Person:_____ Telephone:_____

Readiness for placement: ☐ASAP ☐currently in the Hospital ☐ planning for the future

List any recent inpatient admissions (within the Last year)

Hospital:_____ Dates:_____

Rehab Facility:_____Dates:_____

Nursing Home:_____Dates:_____

If not hospitalized within last year please give date of last physical exam:_____

Has applicant ever been admitted to a state hospital or psychiatric unit? ☐ YES ☐ NO

Name:_____ Dates:_____

Primary Medical Diagnosis:_____

_____

_____

Health Insurance

Medicare #:_____ ☐Part A only ☐Part B only ☐Part D ☐Part A & B

Part D Prescription coverage provider:_____ ID #:_____

HMO Name:_____ ID #:_____

Massachusetts Medicaid (Mass Health) #:_____

Long Term care insurance: _____ Policy#:_____

Monthly Income

Type	Recipient Name	Amount
Social Security	_____	$_____
Retirement (Pension)	_____	$_____
VA Pension	_____	$_____
Rental Income	_____	$_____
Other	_____	$_____

Financial Information/Assets

Name of Bank:	Type of account:	Amount:
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

Do you own: ☐Stocks ☐Bonds ☐CD's ☐Mutual Funds Approximate Value: $_____

Life insurance policy: Company name:_____ Policy#:_____

Beneficiary Name:_____ Face Value:_____

Have you created a trust: ☐YES ☐NO If so what type:_____

Do you own your home? ☐YES ☐NO

Has there been a transfer or gift of more than $750.00 in the past 5 years? ☐YES ☐NO

If yes please explain:_____

*PLEASE NOTE IF YOU ARE APPLYING FOR MASS HEALTH (MEDICAID), THE LOOK BACK PERIOD IS 5 YEARS. THIS IS TO DETERMINE WHETHER THERE HAVE BEEN ANY DISQUALIFYING ASSET TRANSFERS.

Funeral/Burial Arrangements

Funeral Home:_____ Telephone#:_____

City:_____ State:_____

Have arrangements been pre-paid? ☐YES ☐NO

Do you have an account set up for Burial/Funeral expenses? ☐YES ☐NO

I hereby state to the best of my knowledge and belief, the above stated information is true, correct and complete.

I understand that if any information has been falsely represented, this will be a sufficient cause for voiding this application for admission

*All of the information will be kept confidential by Oriol Health Care and will not be released without written permission.

Signature of Applicant (If able):_____ Date: _____

Signature of Responsible Party: _____ Date: _____

Application Check list: Please include the following documentation with this application:

☐ Completed application form

☐ Copies of applicant's insurance cards

☐ Copies of any of the following that apply:

- Power of Attorney
- Health Care Proxy
- Guardianship
- Conservatorship

Please Mail/E-Mail or Fax to the Following:

Oriol Health Care

Attn: Admissions-LTC

52 Boyden Road Suite 209

Holden, MA 01520

E-Mail: Katwood@oriolhealthcare.com

Fax: 508-829-1277

For Inquiries or assistance please contact:

Kimberly Atwood at 774-708-0456